August, 1996

WEST VIRIGNIA INFORMATIONAL LETTER

NO. 99

TO: ALL LICENSED HMOs AND INTERESTED MEDICAL PROVIDERS

RE: HMO PROVIDER BILLING

This letter is to provide clarification with respect to the provisions of W. Va. Code § 33-25A-7a., (hereinafter § 7a) relating to Health Maintenance Organization (HMO) provider contracts, billing of health maintenance organization subscribers by medical providers, and cancellation of contracts with the health maintenance organization by medical providers.

BILLING BY PROVIDERS

There is considerable misunderstanding in both the HMO and the provider communities as to how the provisions of § 7a operate with respect to billing by providers who have not contracted with an HMO. West Virginia Code § 33-25A-7a reads in relevant part as follows:

> (2) No subscriber of a health maintenance organization is liable to any provider of health care services for any services covered by the health maintenance organization if at any time during the provision of the services, the provider, or its agents, are aware the subscriber is a health maintenance organization enrollee.
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> (3) If at any time during the provision of the services, a provider, or its agents, are aware that the subscriber is a health maintenance organization enrollee, that provider of services or any representative of the provider may not collect or attempt to collect from a health maintenance organization subscriber any money for services covered by a health maintenance organization and no provider or representative of the provider may maintain any action at law against a subscriber of a health maintenance organization to collect money owed to the provider by a health maintenance organization.... (emphasis added)

Generally, the above provisions have been understood as a bar for all in state health care providers from billing HMO subscribers for services rendered to the

subscriber. Generally, that is an accurate understanding. However, there are exceptions and conditions to the general rule. These are discussed below.

1. CO-PAYMENTS AND DEDUCTIBLES

An HMO subscriber is responsible for certain co-payments and/or deductibles under HMO subscriber contracts. These co-payments and/or deductibles are not obligations of the HMO. They are obligations of the subscriber to the health care provider. Therefore, the provider can pursue payment of co-payments and deductibles from the subscriber.

2. NONCOVERED SERVICES

This area has been the source of considerable misunderstanding. It should be noted that each of the statutory prohibitions of provider billing of subscribers, as contained in § 7a, forbid provider billing for "services covered" by the HMO. An HMO contract with a subscriber specifies that certain medical services are "covered" by the contract, but only under certain conditions. These conditions are generally, that the subscriber first obtain authorization for the services from their primary care physician (PCP) or other authorized HMO representative, and that the services must be received from providers which have contracts with the HMO (contracting or participating providers). However, HMOs sometimes agree to "cover" services that do not meet these criteria.

If a subscriber knowingly and intentionally elects not to obtain a referral from their PCP and, on that basis, obtains non-emergency services from a non-contracting provider, the service is generally not "covered" by the HMO. If the services are not "covered" by the HMO, the HMO has no obligation to pay either the provider or the subscriber for the service. In order to determine whether the HMO will cover the service, the provider should first bill the HMO. The HMO will then determine whether the service is covered. Therefore, where the subscriber intentionally receives non-emergency services from a non-participating provider and the HMO determines that the services are not covered by the HMO contract, the HMO has no obligation to pay the provider and therefore, that provider may bill the subscriber for the services.

The above statements are made in very general terms and it must be kept in mind by providers that § 7a is intended to be a consumer protection provision for the protection of HMO subscribers. The ability of non-contracting providers to bill HMO subscribers for non-covered services, under certain circumstances, should not be used as a trap for the unwary subscriber who has not been made fully aware in advance by the provider that a service may not be covered by the subscriber s HMO. It is critical that before services are rendered, the billing procedures are made clear to the subscriber by the provider. This is especially critical if the provider intends to attempt to seek payment from the HMO subscriber. As a protection to both the nonparticipating provider and the HMO subscriber, the nonparticipating provider should clearly and, in writing, inform the

HMO subscriber that (1) the provider does not have a contract with the subscriber s HMO; (2) that the service will likely not be covered by the subscriber s HMO; and (3) that the subscriber will be responsible for paying his or her own bill, if the service is not covered by the subscriber s HMO. The provider may want to verify with the HMO before services are rendered whether the services will be covered.

The following scenarios may help illustrate the points made above:

1. On a nonemergency basis, an HMO subscriber with no referral from his or her PCP or other authorization from the HMO seeks treatment from a nonparticipating provider. The HMO subscriber, in completing medical and background information forms, informs the nonparticipating provider that he or she is an HMO subscriber. The nonparticipating provider supplies the HMO subscriber with a clear written explanation that the provider does not participate with the subscriber s HMO and that the subscriber will be expected to pay for all services, since they will most likely not be covered by the HMO. The subscriber signs this form and elects to receive services from the nonparticipating provider. The subscriber s HMO determines that the services are not covered. Upon this set of facts, the nonparticipating provider may bill the HMO subscriber. Since the services are not "covered" by the HMO, there is no prohibition by § 7a from the provider billing the subscriber. There is no obligation for the HMO to pay the provider, and it is appropriate for the provider to obtain payment from the subscriber.

2. An HMO subscriber is referred by the subscriber s PCP to a nonparticipating provider. The subscriber, in completing the nonparticipating provider s health history and insurance information forms, reveals to the nonparticipating provider that he or she is an HMO subscriber. The HMO subscriber then receives services, otherwise covered by the HMO contract (if received from a participating provider) from the nonparticipating provider. Upon this set of facts, the nonparticipating provider may seek payment for normal charges, but may do so only from the HMO. Under § 7a, the HMO subscriber may not be billed except for proper co-payments and/or deductibles (as defined by the HMO contract). In this scenario, the HMO is responsible for payment, and the subscriber may not be pursued.

3. Pursuant to a referral by his or her PCP, an HMO subscriber is being treated by a specialist who has contracted with the HMO as a part of the HMO s provider network. Without the authorization of the PCP, the contracted specialist consults with another nonparticipating specialist on the subscriber s treatment. The nonparticipating specialist is aware that the patient is an HMO subscriber, but makes no effort to inform the subscriber that the nonparticipating specialists charges may not be covered by the HMO. Upon this set of facts, the nonparticipating specialist may seek payment of normal charges for the services from the HMO, however, if the HMO denies coverage of the services solely because the provider is non-participating, the nonparticipating provider may not seek payment from the subscriber (except for amounts attributable to appropriate copayments and deductibles). In this scenario, the HMO may elect to cover

the services regardless of the nonparticipating status of the provider, but in any event § 7a prohibits billing of the subscriber.

4. On an emergency basis, an HMO subscriber receives treatment from a nonparticipating provider. The nonparticipating provider is aware that the subscriber has coverage with an HMO. Under this set of facts, the nonparticipating provider may bill the HMO for normal charges. The HMO subscriber may not be billed except for proper co-payments and or deductibles (as defined by the HMO contract). While instances will necessarily be fact specific, the general rule, as shown in the above examples, is that if the HMO or any of its contractors (PCPs, contracting providers) properly authorizes a subscriber to receive services covered by an HMO contract, the provider must seek payment from the HMO, and not from the HMO subscriber. The fact that the service provided by the noncontracting provider is a "covered service" obligates the HMO for the payment of the nonparticipating provider s normal charges, and the provider's recourse for payment is with the HMO.

CANCELLATION OF CONTRACTS

This letter also serves as a reminder that any provider intending to cancel his or her contract with the health maintenance organization must provide written notice to the health maintenance organization and the West Virginia Commissioner of Insurance pursuant to the provisions of W. Va. Code § 33-25A-7a which provides in relevant part as follows:

> (7) For all provider contracts executed on or after the fifteenth day of April, one thousand nine hundred ninety-five, and within one hundred eighty days of that date for contracts in existence on that date:
>
> (a) The contract must provide that the provider shall provide sixty days advance written notice to the health maintenance organization and the commissioner before canceling the contract with the health maintenance organization for any reason . . . . (emphasis added)

Providers who have not complied with the requirements of this statute may continue to be responsible for the provision of medical services to subscribers until proper notice is given.

Hanley C. Clark
Insurance Commissioner